FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory**:** **Montana**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Nancy Ellery, Health Policy and Services Division Administrator,
Department of Public Health and Human Services

SCHIP Program Name (s) Montana Children's Health Insurance Plan (CHIP) Program

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
__X__ Separate SCHIP Program Only
____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program? s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ?NC? for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. **Program eligibility –**
   - The Department chose to perform eligibility and enrollment activities in-house instead of through a contractor. An Eligibility Supervisor and four Eligibility Specialists were hired and trained in early FFY 2000.
   - Income disregards which reduced countable income used to test against CHIP income guidelines were implemented. Those disregards are 1) up to $200 per month for dependent care for each dependent child or incapacitated adult who is living in the household and cared for by someone who is not a member of the household; 2) the first $120 of each wage earner's monthly income is deducted from gross earnings, whether employed full or part time.
   - The 2000 federal poverty guidelines were implemented May 1, 2000.

2. **Enrollment process –**
   - The $15 enrollment fee was eliminated and the maximum copay was increased from $200 to $215 per child per benefit year.

3. **Presumptive eligibility** - NC

4. **Continuous eligibility –** NC

5. **Outreach/marketing campaigns –**
   - Family education and outreach efforts were initiated and marketing materials were developed (they were not part of the previous year's CHIP Pilot Program).

6. **Eligibility determination process –**
   - At the end of the fiscal year, CHIP eligibility training was conducted for staff from three county Offices of Public Assistance (OPA). In October 2000, those OPA staff began to process applications, determine eligibility and enroll eligible children in CHIP. In the past, these functions were performed only by the central state CHIP eligibility staff.

7. **Eligibility redetermination process** - NC

1. **Benefit structure –**
   - Prescription benefit for contraceptives was discontinued at the direction of the legislature.
   - Dental services have been added as a covered benefit and are paid on a fee for service basis by DPHHS. During the fiscal year, orthodontic services were discontinued as covered benefits and the maximum benefit for dental services was increased from $200 to $350 per child per benefit year.
   - Eyeglasses have been added as a covered benefit and are paid on a fee for service basis by DPHHS.
   - Mental health benefits were expanded for CHIP children with a diagnosis of severe emotional disturbance.

9. **Cost-sharing policies –**
   - Cost-sharing for Native Americans was discontinued.
   - Enrollment fee was eliminated

10. **Crowd-out policies** – NC

11. **Delivery System**
   - The Department continues to contract with one indemnity plan, Blue Cross Blue Shield (BCBS) of Montana, and pays a monthly premium for each child with CHIP coverage. (BCBS' product is called BlueCHIP.) Negotiations with another insurance company were conducted this fiscal year but did not result in a contract with that company.

1. **Coordination with other programs (especially private insurance and Medicaid) –** NC

2. **Screen and enroll process -** NC

3. **Application -**
   - The Department developed and implemented the universal application so that families can use one form to apply for Medicaid, CHIP, Mental Health Services Plan (MHSP), Children's Special Health Services (CSHS) and The Caring Program for Children.
   - Each family whose children had CHIP for a year and needed to reapply were sent a letter and application 60 days prior to the expiration of benefits. If any application was not received within 30 days, a reminder flyer was mailed. If there was still no response, a telephone call was made to the family encouraging them to reapply and avoid a lapse in coverage.

4. **Other -** NC

1.2 Please report how much progress has been made during FFY 2000 in reducing the number

of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

   The number of enrolled children in the CHIP program at the end of fiscal year is 7,538. This is 6,621 more than the 917 children who had CHIP last fiscal year. (The actual number of ever-enrolled children was 7,704 in FFY 2000 and 1,019 in FFY 1999.)

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information**.**

   According to the Medicaid data system, there were 96,767 children eligible for Medicaid in FFY 1999 and 97,111 children eligible for Medicaid in FFY 2000. The FFY 2000 number is not final due to possible retroactive eligibility. We expect the FFY 2000 number to be finalized early next year.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

   The Caring Program for Children, a public-private partnership administered by Blue Cross Blue Shield of Montana, provided coverage for 615 children at the beginning of the fiscal year and 641 children were covered at the end of the year. Children's Special Health Services, funded by Title V Maternal and Child Health monies, provided health care services or reimbursement for services not covered by Medicaid or other health insurance for419 children during the fiscal year**.**

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   _X_ No, skip to 1.3

   ____ Yes, what is the new baseline?

   What are the data source(s) and methodology used to make this estimate?

   What was the justification for adopting a different methodology?

   What is the State**?** s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State? s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State? s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State? s strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ?NC? (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Decrease the proportion of children in Montana who are uninsured and reduce financial barriers to affordable health care coverage	Decrease the proportion of children ≤ 150% FPL who are uninsured	Data Sources: Current Population Survey ***Methodology: 1994, 1995 and 1996 merged data set (baseline) comparison with FFY 2000 data*** Numerator: Number of children ≤ 150% FPL who were uninsured Denominator: Number of children ≤ 150% FPL ***Progress Summary: As of September 30, 2000, the program has reduced the number of uninsured children by 7538.*** ***Enrollees who left CHIP before their 12 months of eligibility expired were surveyed to learn why they were no longer enrolled in CHIP. These reasons for disenrollment will be captured but are not yet available.***
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Enroll eligible children in the CHIP program	Enroll 10, 000 children who are under 150% FPL in the CHIP program by September 30, 2000	Data Sources: Internal CHIP data system Methodology: Number of enrolled children reported by the system through September 30, 2000 Progress Summary: As of September 30, 2000, 7,538 children had been enrolled in CHIP. Because of the expanded dental benefits (from $200 to $350 per child per benefit year) the targeted number of enrollees is 9,725 by December 31, 2000.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Increase the enrollment of currently eligible, but not participating,	Ensure that 50% of children referred from CHIP to Medicaid enroll in	NC Although CHIP has defined the information to be obtained in report format from the

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
children in the Medicaid program	Medicaid	eligibility and enrollment data system, that data is not yet available.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Improve the health status of children covered by the CHIP program with a focus on preventive and early primary treatment		Data Sources: HEDIS data gathered by insurance plans Methodology: DPHHS to review HEDIS data for enrollees Numerator: Number of children with immunization and well-child care Denominator: Number of CHIP enrollees Progress Summary: Not available – QA system dependent upon one year of data- not available at this time.
OTHER OBJECTIVES		
Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children	Enroll a minimum of 50% of children on the waiting list for the Caring Program for Children into CHIP by December 1, 1999	NC
	Coordinate with the Title V Children with Special Health Care Needs	Data Sources: Internal CHIP data system Methodology: Review of referral data to CSHCN and MHSP programs

	(CSHCN) and the Mental Health Services Program (MHSP) to ensure that children who need care beyond what is offered under CHIP are referred to these programs	Numerator: Number of children referred to CSHCN and MHSP Denominator: Number of children needing care from CSHCN and MHSP Progress Summary: Extensive outreach to children in the Mental Health Services Plan has been conducted. Through these efforts, 200 of the 781 total MHSP children were dually enrolled (26%) in FFY 2000. Four percent (4%) of the active CSHCN clients were also eligible for CHIP in FFY 2000. Care coordination meetings were held between CHIP and CSHCN on individual high need children and the referral tracking system is under development in the CHIP data system.
Prevent "crowd out" of employer coverage	Maintain proportion of children ≤ 150% FPL who are covered under and employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy	Data Sources: Current Population Survey ***Methodology: 1994, 1995 and 1996 merged data set (baseline) comparison with FFY 2000 data*** Numerator: Number of children ≤ 150% FPL who were insured through employer coverage Denominator: Number of children ≤ 150% FPL Progress Summary: The portion of the eligibility data system which will capture the numbers of children whose parents have insurance will be put into production in February 2001. The data is not available at this time.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

The development of a new eligibility and enrollment system, and subsequent enhancements due to program changes, have been a barrier to obtaining data to determine whether performance goals have been met.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

Not Applicable

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

We expect to be interviewing and hiring a Data Analyst for CHIP in January 2001. That person will be responsible to monitoring and measuring performance data. We also continue to work on development and enhancement of our data system and expect data to be available by September 31, 2001.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

There are no program performance attachments available at this time.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

Not Applicable

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults 0
Number of children 0

3. How do you monitor cost-effectiveness of family coverage?

Not Applicable

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

Not Applicable

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults 0
Number of children 0

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

Crowd-out is defined as the substitution of publicly funded health coverage for private health insurance.

2. How do you monitor and measure whether crowd-out is occurring?

The universal application asks if children currently have health insurance or if they've had health insurance in the past three months. Children must be uninsured for three months before being enrolled in CHIP. Some employment-related exceptions apply.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

   Data not available.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

   Anecdotal reports from applicants, outreach contractors, Montana Covering Kids advocates and the general public indicate that the three month waiting period discourages potentially eligible families from substituting private insurance with public coverage.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

   We must stress that the success was not because of one particular outreach activity but the result of coordinated efforts on both the state and community level. The five outreach strategies employed were: 1) direct appeal to eligible families through press releases, public service announcements and videos; 2) outreach through schools; 3) outreach through collaboration with local agencies, grassroots organizations and providers; 4) outreach collaboration with statewide maternal child health organizations; and 5) a statewide media advertising campaign, including television, radio, and print media.

   Montana Covering Kids advocates and Medicaid/CHIP outreach contractors working in their local communities were highly effective. The advocates and contractors indicated that they found the following activities to be most successful:

   - working one on one with families to complete applications
   - sending information and applications home to families with children attending Head Start programs, pre-schools, schools, WIC offices and county health departments.
   - Providing information and applications to doctors' offices to distribute to parents whose children were uninsured.

   The six-week statewide media campaign that was conducted in August & September 2000 was especially effective in getting potentially eligible families to apply and become enrolled in CHIP. During July 2000 our contractor, Healthy Mothers Healthy Babies (HMHB) mailed out applications to 180 individuals who requested them through Montana's 1-800-KIDS NOW toll-

free line. After the initiation of the media campaign this number increased to 524 in September and 510 in October. During FFY 2000 the state CHIP office was receiving an average of 460 applications per month. After the initiation of the six- week media campaign this number increased to 1,227 in September and 1,124 in October.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

   The outreach activities listed above were successful for all populations. Door-to-door outreach efforts on reservations were especially effective in reaching Native American families. Advocates report that having a Native American person from the reservation provide the information and assist in the application process resulted in greater acceptance of the health coverage programs.

   Outreach efforts by Indian Health Service (IHS) facilities were extremely effective. IHS staff explained to families that IHS is not health insurance and the advantages to families (and IHS) to having their children insured. The IHS staff screened their patients to determine if children were uninsured, gave information, assisted in completing applications and provided follow-up during the eligibility determination process.

3. Which methods best reached which populations? How have you measured effectiveness?

   See response to questions 1 & 2 above.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

   To ensure that eligible children stay enrolled in CHIP we have implemented the following:
   - 12 month continuous eligibility
   - Re-enrollment packet and follow-up reminder
   - Follow-up phone calls are made as staff time permits

   To ensure that eligible children stay enrolled in Medicaid they have implemented the following:
   - The face to face interview requirement was eliminated in July 2000. This allows families to apply for Medicaid through the mail.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

   Note: Montana does not have children who disenroll from CHIP but are still eligible. The following responses pertain to CHIP children who are eligible and need to reenroll.

___ Follow-up by caseworkers/outreach workers

_X_ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population _____
____ Information campaigns
____ Simplification of re-enrollment process, please describe _____
____ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
_X_ Other, please explain_____
A CHIP family receives a letter and application 60 days prior to the expiration of CHIP coverage and 30 days later a reminder notice is sent if an application has not been returned.

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

   No. Medicaid is not undertaking any special measures.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

   October 2000 was the beginning of annual re-enrollment so our experience is limited. We are participating in a study conducted by North Dakota about CHIP re-enrollment and retention in Region VIII, Nebraska and Iowa. Those study results will be shared with participating states and will affect the policies and activities that we implement in Montana.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

   We have no data about insurance coverage for those children who disenroll or do not reenroll. With enhancements to our data system, we hope to have this data available by September 30, 2001.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

   CHIP uses a universal application for CHIP, Medicaid, MHSP, CSHS and The Caring Program. However, the application and redetermination requirements differ. CHIP has 12 month continuous eligibility and does not have an asset test. Medicaid has month to month eligibility, presumptive eligibility, a $3,000 asset test and requires a greater amount of supporting documentation than CHIP.

1. Explain how children are transferred between Medicaid and SCHIP when a child**?**s eligibility status changes.

When children lose Medicaid coverage due to an increase in family income, Medicaid eligibility staff can enroll children in CHIP. All CHIP applications are screened for Medicaid eligibility and if determined to be potentially eligible for Medicaid, the application and all supporting documents are forwarded to the appropriate for a determination via e-mail, telephone or fax. Staff coordinate activities to ensure that eligible children are covered by Medicaid or CHIP.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   The delivery systems for CHIP and Medicaid are not the same, although the providers are often enrolled in both programs' networks. CHIP contracts with Blue Cross Blue Shield of Montana which as one of its responsibilities, enrolls and supports medical and allied providers as well as hospitals. The CHIP Program contracts with Consultec, Inc. to enroll and support dental and eyeglasses providers. Medicaid enrolls and supports its medical, allied and dental providers through two contractors, Maximus, Inc. and Consultec, and directly through the state Medicaid program staff.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   Our CHIP program does not have premiums. We did have a $15 annual family enrollment fee for families over 100% of poverty. Our informal assessment of the effect of this fee found that applicants were confused as to whether the fee applied to them and some Native Americans objected to the fee because existing treaties with the federal government contain provisions for "free" health care. Applications received without the enrollment fees delayed the enrollment process because applicants had to be notified and submit the fee before eligibility could be determined. The fee also proved to be administratively burdensome when an applicant submitted the fee, was found to be ineligible and the fee needed to be returned to the applicant.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

   Anecdotal reports from families, outreach contractors and Montana Covering Kids advocates indicate that the co-pay amounts and the co-pay maximum are reasonable. They do not appear to be a barrier to utilization of health services. Anecdotal reports also show that providers often waive co-payments for CHIP enrollees.

2.7 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Beginning last Spring, we began collecting data regarding complaints and grievances to our insurance contractor, Blue Cross Blue Shield of Montana, and to the Montana CHIP program. While we have a limited (approximately 5 months) data, there does not appear to be a problem with quality of care received by enrollees. Of the sixteen complaints received, seven applicants complained about the eligibility process. Four calls were related to a problem with a provider. No provider had more than one complaint and each was followed up on an individual basis and resolved. Two callers wanted provider reimbursement for services that were not covered benefits. One person complained about having difficulty accessing CHIP dentists; one complained that the phone line was "busy all the time" and one had a problem with claim reimbursement.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

   Health Plan Employer Data and Information Set (HEDIS) measures and complaint and grievance data will be used to monitor and assess quality of care.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

   We plan to continue to use HEDIS measures and complaint and grievance data. HEDIS data will be available in March 2001 and annually thereafter. Complaint and grievance data is currently available for FFY 2000.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility

Barrier: Incomplete eligibility and enrollment computer system.
Success: Continuing efforts to improve the eligibility and enrollment computer system. Well-trained, dedicated, centralized eligibility specialists. The Department developed the universal application for coordination among programs.

2. Outreach

Barrier: Montana's large land area and sparse population; few population centers
Success: Montana's involved community-based & grassroots organizations.

The Department, using federal Medicaid matching funds, contracted with Healthy Mothers Healthy Babies (HMHB) to support the Montana Covering Kids (MCK) project funded by the Robert Wood Johnson Foundation. The goal of MCK is "to improve the health and well being of Montana's children by conducting outreach activities to identify and enroll uninsured children in health coverage programs and coordinating state and local program efforts to expand children's access to health coverage." These activities were conducted by HMHB and their thirteen community coalitions throughout Montana.

The Department also initiated thirty-one outreach contracts statewide with Native America tribes, county health departments, the Migrant Health Council, and other non-profit community agencies to perform Medicaid and CHIP outreach activities. (Federal Medicaid matching funds were accessed for these contracts as well).

In addition to ongoing outreach efforts by the state outreach coordinator, MCK coalitions and Department contractors, a statewide media campaign (television, radio, billboards, newspaper ads, etc.) was conducted to encourage families to obtain free or low-cost health insurance for their children.

3. Enrollment

Success: Montana enrolled 80% of target in the first year (FFY 2000); 100% of target by December 31, 2000 (13 months after start)

4. Retention/disenrollment

Barrier: Need better data to determine reasons for families' failure to reenroll children

5. Benefit structure

Barrier: Limited funding prohibits provision of some important benefits for special needs children.
Success: The benefit package is rich enough to provide most needed benefits to general CHIP population. Expanded dental and mental health benefits.

6. Cost-sharing

Success: Co-payments are charged only for families whose income is greater than 100% of FPL and co-payments are low enough to not be a barrier.

7. Delivery systems

Success: Our insurance partner, BCBSMT, has created an extensive provider network. A BCBSMT official reported that it is a better network than for any other plan they offer - due to the popularity of CHIP with providers. During this fiscal year, the network of BlueCHIP providers increased from 585 (physicians=231; allied providers=340; hospitals=14) to 2,379 (physicians=1,107; allied providers=1,174; hospitals=98) during the fiscal year.

Dental benefits were instituted at the beginning of this fiscal year. At that time we had a network of 68 dental providers practicing in 70 locations throughout Montana. By the end of the fiscal year there were 158 dental providers in 165 locations.

8. Coordination with other programs

Success: The development and implementation of the universal application. Monthly meetings between CHIP and State Medicaid eligibility staff as well as CHIP and BCBSMT staff. CHIP and Medicaid Services are in the same bureau of DPHHS and bureau meetings occur semi-monthly.

9. Crowd-out

Barrier: The three month waiting period is a hardship for many families whose children had insurance but the families can no longer afford the premiums. Many employers in Montana saw a huge increase in insurance premiums during FFY 2000. Success: The development and implementation of the universal application. Monthly meetings between CHIP and State Medicaid eligibility staff as well as CHIP and BCBSMT staff. CHIP and Medicaid Services are in the same bureau of DPHHS and bureau meetings occur semi-monthly.
Success: In early FFY 2000, monitoring of crowd-out was initiated by distributing a "CHIP Enrollee Questionnaire" to all active CHIP Pilot families. Families were asked, "Were your children ever covered by health insurance before they were covered by CHIP? (Do not include coverage by Medicaid, Indian Health Service or the Caring Program.) Seventy-eight percent (78%) of the families who responded indicated that their children had never been covered by health insurance before they were covered by CHIP.

10. Other

Success: The development and implementation of the State Administrative Rules for the CHIP program , the CHIP Policy Manual and the CHIP Dental Provider Manual. The development and submission of the CHIP State Plan Amendment and the FFY 1999 CHIP Evaluation Report. The initiation of contract negotiations with insurance partner, BCBSMT, for FFY 2000.

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

12/21/00 requested help from Mary N. to complete this table. It looks like I should include a narrative as well.

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles	**3,499,470**	**10,810,561**	**11,835,714**
Fee for Service	**2,348105**	**2335006**	**1309853**
Total Benefit Costs	**5,847,575**	**13,145,567**	**13,145,567**
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	**5,847,575**	**13,145,567**	**13,145,567**
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	**584,757**	**1,314,557**	**1,314,557**
10% Administrative Cost Ceiling	**584,757**	**1,314,557**	**1,314,557**
Federal Share (multiplied by enhanced FMAP rate)	**5,185,103**	**11,829,549**	**11,795,955**
State Share *	**1,247,229**	**2,776,636**	**2,810,230**
TOTAL PROGRAM COSTS	6,432,332	14,606,185	14,606,185

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

The Montana CHIP Program does not have family coverage. Therefore, we have no total State expenditures for family coverage.

The following are the FFY 2000 total expenditures for the CHIP program:

Total computable share (admin + benefits)	$5,319,940.27	
Total federal share (admin + benefits)	4,288,403.85	
Total state share (admin + benefits)	1,031,536.42	

Fee-for-Service (Admin only)

Total computable share	$531,994	
Total federal share	428,840	(@80.61%)
Total state share	103,154	(@19.79%)

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No change in source of non-Federal share is expected at this time.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		Montana CHIP Program
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff __X_Other *(specify)* State CHIP eligibility staff
Average length of stay on program	Specify months _____	Specify months Data not availabale
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __**X**_Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	__X_No _____Yes
Can apply for program over internet	_____No _____Yes	__X__No _____Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Requires face-to-face interview during initial application	_____No _____Yes	__**X**__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months _____ What exemptions do you provide?	_____No __X__Yes, specify number of months ___3___ What exemptions do you provide? If parent or guardian dies; was fired or laid off; can no longer work due to a disability; has a lapse in insurance coverage due to new employment; or has an employer who no longer offers dependent coverage.
Provides period of continuous coverage <u>regardless of income changes</u>	_____No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____No __X__Yes, specify number of months ___12___ Explain circumstances when a child would lose eligibility during the time period. When a child obtains Medicaid or other health insurance, moves out of state or dies.
Imposes premiums or enrollment fees	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	__X__No - Discontinued enrollment fee 6/1/00 _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	_____No _____Yes	_____No __X__Yes – Maximum = $215 per family per benefit year
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__X__ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The application must be completed and submitted with required documentation for both the initial application and redetermination process. However, current CHIP recipients are notified at 60 and 30 days prior to expiration of benefits that they need to reapply. Applications for recipients reapplying for CHIP receive priority in processing in order to avoid or minimize a lapse in CHIP coverage.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	133% of FPL for children under age 6 100% of FPL for children aged 6 or born after 10-1-83 40.5% of FPL for children aged born before 10-1-83
Medicaid SCHIP Expansion	____% of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	150 % of FPL for children aged 0 – 18 ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes __X_ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$120/mo./each	$	$120/mo./each
Self-employment expenses *	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$	$	$
Paid	$	$	$
Child care expenses	≤ 200/mo./child	$	≤ 200/mo./child
Medical care expenses	$	$	$
Gifts – Non-recurring	$	$	$
Other types of disregards/deductions (specify)	$	$	$

* Depreciation of business equipment; self-employment taxes – amount varies.

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups ____No __X_ Yes, specify countable or allowable level of asset test_$3,000__
Medicaid SCHIP Expansion program ____No ____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program __X_ No ____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____ ____No ____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes _X_ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001 (10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage - NC

2. Employer sponsored insurance buy-in – NC

3. 1115 waiver – NC

4. Eligibility including presumptive and continuous eligibility - NC

5. Outreach – The Department's contract with Healthy Mothers Healthy Babies (HMHB) for the Montana Covering Kids (MCK) project expired December 31, 2000. The goal of this project is "to improve the health and well being of Montana's children by conducting outreach activities to identify and enroll uninsured children in health coverage programs and coordinating state and local program efforts to expand children's access to health coverage." These activities were conducted by HMHB and their thirteen community coalitions throughout Montana. Medicaid and CHIP outreach activities were also performed by Native America tribes, county health departments the Migrant Health Council, and other non-profit community agencies under contract with the Department..

   Beginning in January 2001, the Department will be offering contracts directly to the (MCK) coalitions as well as Native America tribes, county health departments, Federally Qualified Health Centers, Rural Health Clinics, Community Health Clinics, the Migrant Health Council, and other non-profit community agencies to provide outreach and application assistance to families eligible for health coverage programs such as Medicaid and CHIP.

6. Enrollment/redetermination process – requesting enhancements to computer system to streamline and make redetermination process easier for current enrollees.

7. Contracting - NC

8. Other – Effective August 15, 2000, all children applying for the Mental Health Services Plan (MHSP) must first apply for CHIP. Benefits will be coordinated for children with dual eligibility for CHIP and MHSP, with CHIP being the primary payor. In January 2001, the MHSP eligibility staff will become a part of the CHIP section. The CHIP section will then be responsible for eligibility determination and enrollment for MHSP and CHIP.